

EXHIBIT B

Maricela Rodriguez

From: Adam Kleinberg
Sent: Wednesday, August 17, 2022 3:13 PM
To: Kevin P. Krupnick
Cc: Corey Ribotsky
Subject: Re: Vlahopolous v. Roslyn
Attachments: Dr Katz HIPPA 08172022.pdf; Dr Kaufman HIPPA 08172022.pdf

Thanks. I will review them. I did not receive the supplemental document responses as promised. Please advise. My motion is drafted but I will hold off for today in the hopes you provide the items today.

Sent from my iPhone

On Aug 17, 2022, at 11:01 AM, Kevin P. Krupnick <kpkrupnick@krupnickfirm.com> wrote:

Adam,
Annexed hereto in PDF format are (a) Two HIPPA forms for Victoria Katz for both of her physical addresses and (b) One HIPPA form for Samantha Kaufman. Should there be any further issues with these care providers authorizations, please let me know.

Kevin P. Krupnick, Esq.
The Krupnick Firm
56 Hammond Road
Glen Cove, New York 11542
516-592-2820

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

[This form has been approved by the New York State Department of Health]

Patient Name Athanasios Vlahopoulos	Date of Birth 12/13/2002	Social Security Number 089-92-8552
Patient Address 410 Motts Cove South. Roslyn Harbor NY 11576		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

Vicoria Katz, DO 1554 Northern Blvd Floor 1, Manhasset NY 11030

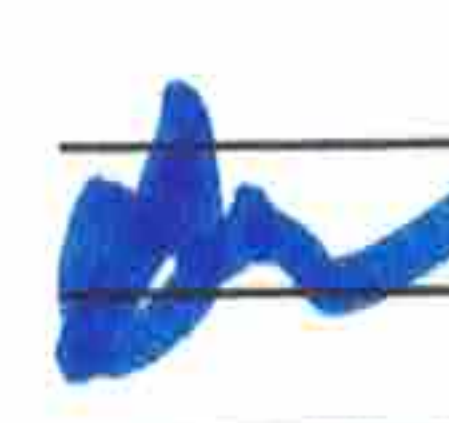
8. Name and address of person(s) or category of person to whom this information will be sent:

Adam Kleinberg, Esq., Sokoloff & Stern LLP 179 Westbury Avenue Carle Place NY 11514

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (Indicate by Initialing)

 **Alcohol/Drug Treatment**
Mental Health Information
HIV-Related Information

Authorization to Discuss Health Information(b) ☒ By initialing here _____ I authorize **Victoria Katz**

Initials

Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

Kevin P Krupnick, Esq./The Krupnick Firm 56 Hammond Rd Glen Cove NY 11542

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:


- ☒ At request of individual
- ☐ Other: _____

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.


Signature of patient or representative authorized by law.

Date:

8/17/2022

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: Dr. Victoria Katz 1225 Franklin Avenue Suite 325 Garden City NY 11530	
8. Name and address of person(s) or category of person to whom this information will be sent: Adam Kleinberg, Esq., Sokoloff & Stern LLP 179 Westbury Avenue Carle Place NY 11514	
9(a). Specific information to be released: <input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____ <input checked="" type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers. <input type="checkbox"/> Other: _____ <div style="text-align: right;">Include: (Indicate by Initialing)  Alcohol/Drug Treatment Mental Health Information HIV-Related Information</div>	
Authorization to Discuss Health Information (b) <input checked="" type="checkbox"/> By initialing here _____ I authorize Victoria Katz Initials _____ Name of individual health care provider _____ to discuss my health information with my attorney, or a governmental agency, listed here: Kevin P Krupnick, Esq./The Krupnick Firm 56 Hammond Rd Glen Cove NY 11542 (Attorney/Firm Name or Governmental Agency Name)	
10. Reason for release of information: <input checked="" type="checkbox"/> At request of individual <input type="checkbox"/> Other: _____	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.



Signature of patient or representative authorized by law.

Date: **8/17/2022**

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7. Name and address of health provider or entity to release this information: Dr. Samantha Kaufman 400 Jericho Tpk Suite 209 Jericho NY 11753	
8. Name and address of person(s) or category of person to whom this information will be sent: Adam Kleinberg, Esq., Sokoloff & Stern LLP 179 Westbury Avenue Carle Place NY 11514	
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